NEW YORK STATE OF OPPORTUNITY. | Department of Health

Integrated Care Workgroup

Meeting #11

Discussion document

January 11, 2016

Agenda – ICWG 11

Timing	Topic	Lead
10:00-10:30am	Welcome / updates on timeline	▪ Foster Gesten, Susan Stuard, John Powell
10:30-11:15am	Updates on model: Performance milestones, Behavioral health	▪ Foster Gesten ▪ Lloyd Sederer
11:15-11:45am	Approach to Gate determination	▪ Susan Stuard, Marcus Friedrich
11:45-12:00pm	Working lunch	
12:00-12:45pm	Update on APC scorecard	▪ Pat Roohan
12:45-01:30pm	Discussion of payer and provider business cases	▪ David Nuzum
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Our core working group has been working on multiple materials to be published in 2016

See details on p 6-7

Activity	Description	Status	Next steps
FAQ	Frequently Asked Questions on APC, including model design, reasons to participate, and approach to special cases	▪ Distributed to ICWG ▪ Published on APC website	▪ Published
Business case	Assumptions and associated financial implications of a general business case for payers and providers	▪ Distributed to payers ▪ To be discussed today	▪ To be discussed today
Information request	Written request of NYS payers to understand current approach to primary care payment and future approach to APC	▪ To be distributed to payers soon in January	▪ Responses anticipated in February
Milestones technical specs	Details behind each milestone defining what it means to "pass" and materials required in submission	▪ Draft being shared with a working team	▪ Finalization early February
PT RFA	Request for applications for practice transformation technical assistance entities, using a majority of the $67M earmarked for practice transformation	▪ Draft complete, in final approval stages	▪ Release Q1 2016
Oversight RFP	Request for proposals for single APC oversight entity, auditing and verifying PT TA performance and milestone achievement	▪ Draft in progress	▪ Release Q1 2016

Multiple Avenues for Continued Feedback

Activity update

- NEBGH has conducted two sets of listening sessions in each of eight regions in Spring and Fall 2015
- State-wide webinars for national and regional employers
- Held monthly meetings with national and regional health plans
- Formation of the SIM Purchaser Advisory Council
- Meeting with Benefit Consultants
- Conducted meetings with individual employers and regional business coalitions (e.g. GE, Marist College, Mid-Hudson Empire State Development, and Westchester County Association)

Stakeholder Feedback

Health plan feedback

- More dialogue needed on APC model alignment with existing payer models – ACOs
- Imperative to understand specifics of business case - expected investments and returns
- Pushback on financing practice transformation
- Questions around overall return on investment
- Data needed to drive better physician performance
- Practices need to take on risk down the road – not just share in savings
- Concerns about buy-in from self-funded employers – need stronger business case
- Support from both DFS and CMS critical
- Importance of multi-payer critical mass to promote effectiveness and reduce free-riding
- Interest in specifics of gate assessments

Purchaser feedback

- Employees in multiple states – how to align with other SIM initiatives
- Concerns about PCP shortages in context of increased demand
- Benefit design and education must support consumer engagement
- Support for common core measures and attribution – recommend small sub-set to start
- Attribution approach needs simplicity
- Recognize plans have multiple value-based payment strategies - physicians don't have capacity to handle administrative burden
- CMS value-based initiatives add further complexity – all will fail without alignment

Goals of the DFS information request

The DFS information request is meant to continue the call and response with payers in a more formal, structured way towards finalization of the APC model

Call

We are sharing the APC model with payer representatives in detailed, written form in order to

- Respond to frequent requests for definitive detail
- Allow these stakeholders to begin internally synthesizing and preparing for APC implementation
- Provide payers with sufficient information to return a meaningful response

Response

The input gathered from payers will be used to

- Understand the current lay of the land of VBP in New York
- Determine the criteria and mechanisms for existing VBP contracts with providers to be integrated into APC
- Understand the types of APC-qualified contracts that could be available to providers
- Identify key issues and roadblocks to be resolved during APC implementation
- Confirm the timeline for APC launch and inform expectations for roll-out

Timeline for DFS information request

1. DFS information request will be released soon in the month of January
2. Q&A call will be held approximately one week later with written clarifications issued shortly thereafter
3. Payers will be given ~5-6 weeks to respond after request release
4. Payer submission to DFS / DOH of 2017 APC approach in Q2 concurrent with Rate Review submissions

Refinement of APC timeline to ensure launch with scale

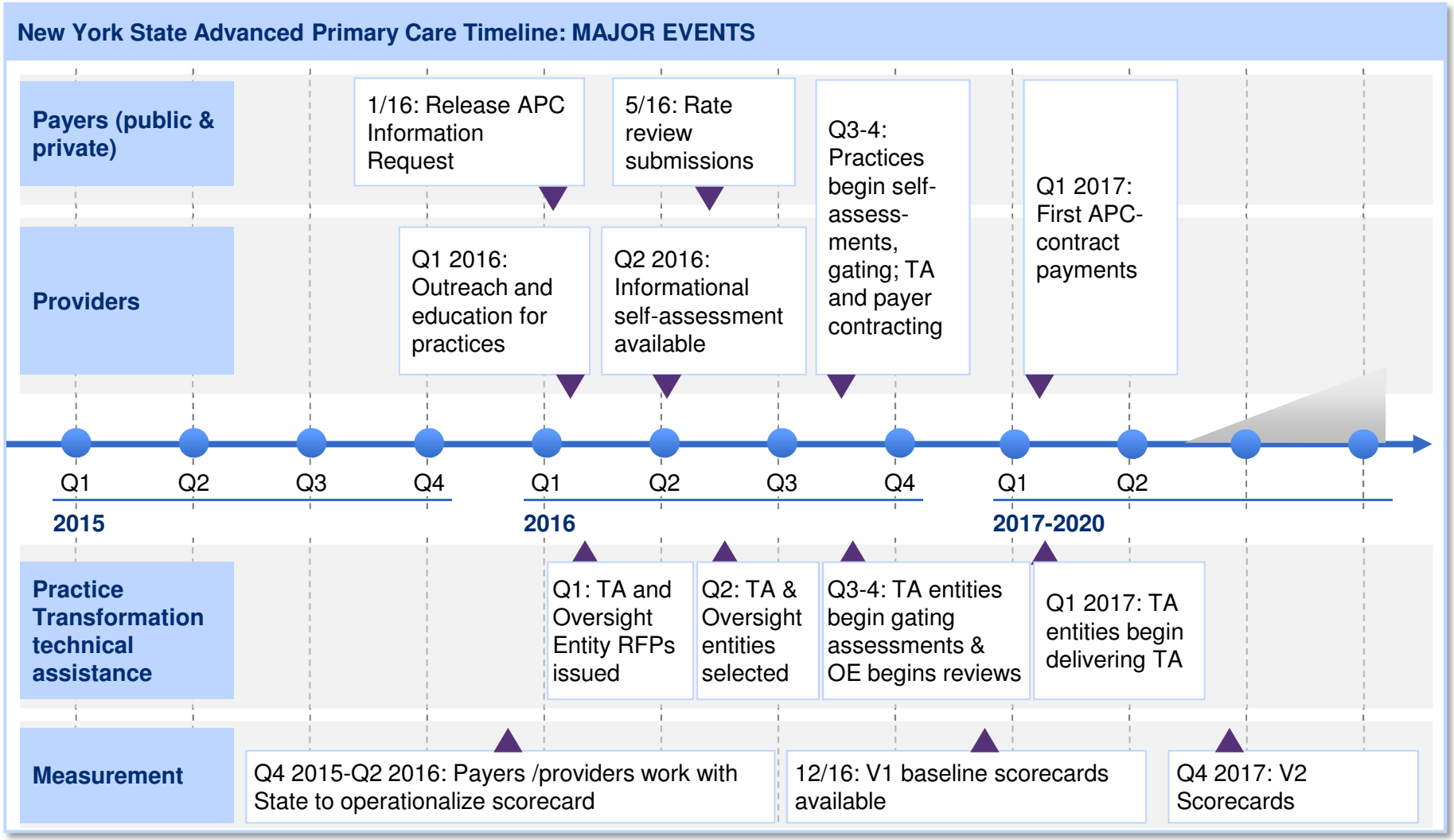
Context
Stakeholder, technical, and operational realities

- **Payer 2016 budget cycles** are set; new 2016 investments would be disruptive and difficult to obtain
- **Rate review** approves rates for new calendar year
- **Vendor timelines** are tight and critical to ensure smooth start-up at scale
- **Scorecard alignment** on strategy, specs, and operational plan ongoing

Refined timeline
Continued refinement 2016, staged launch starting Q3 2016, full launch January 2017

- **Q1-Q2 2016:** Continue **payer commitments to APC**, aligned payment models, Rate Review submissions, and scorecard alignment
- **Q3 2016: Provider** self-assessments, gating, and TA service contracts begin
- **Q3 2016: Provider-payer contract amendments**
- **Q4 2016: Baseline scorecards**
- **Q1 2017: Performance periods and TA** begin for most practices (selected practices may begin PT earlier)

Overview of 2016 major events leading to full Jan 2017 implementation



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Questions for you

For discussion

1. **What are your comments / questions / concerns on the implementation timeline?**

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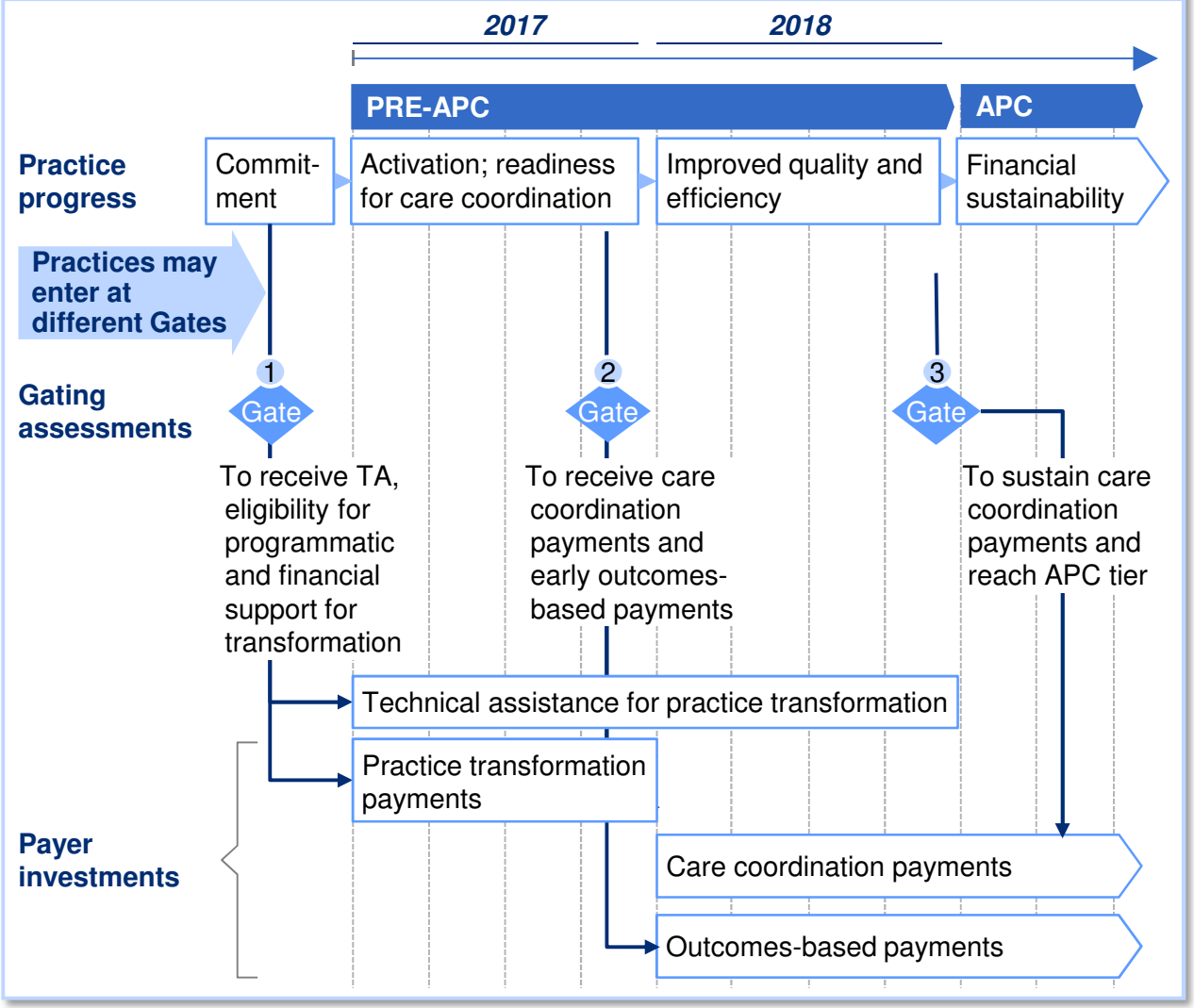
Overview of APC model

- This reviews a **common APC framework** in which individual payers develop and implement APC-qualified contracts
- Components of APC include:
  - Practice **Capabilities** within the APC model
  - **Milestones** that define a practice's capabilities over time
    - **Structural milestones** – describing practice-wide process changes
    - **Performance milestones** – describing performance on Core Measures
  - **Core Measures** that ensure consistent reporting and incentives
  - **Outcome-based payments** structured to promote and pay for quality and outcomes

A common on-site assessment determines initial starting points and certifies practices' progress through **Gates** which mark progress through pre-specified structure/process and performance Milestones, triggering payer commitments such as payments

Review: path to APC for a practice starting at Gate 1 in 2017



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Three main updates to APC Milestones are in progress

Structural	**A** **Behavioral health** – discussing additions proposed by OMH colleagues
	B **Payment requirements** – adding reference to CMS categories for consistency
Performance	**C** **Performance** –adding specific Gating requirements based on practice-wide performance (drawing on V1 Scorecard)

A Core elements of integrated behavioral health in primary care

Screening and Dx (a screen is not a DX)

Treatment to Target (aka Measurement Based Care) using guideline consistent approaches and a registry or even Excel spread sheet

Performance Measurement (and reporting) for several reasons (at least):

1) to ensure that what needs to be done is being done
2) to identify where not and get on that to make it better (aka QI)
3) to show what works and what does not for which practices and which patients (the same shoe is not apt to fill all the feet of primary care)

Effective Referral Management to Specialty Behavioral Health Services

Patient Education and Activation

MD and Staff Training

$$ to support the indirect costs of integrated care

AND some **staff member(s)** (sometimes a care manager) to:

- Engage patients in their own care
- To form the patient relationships needed to sustain ongoing care
- To nudge doctors to do what needs to be done because it will pay off for them, not only their patients

B Updates to structural Milestones

DRAFT

	Commitment Gate 1	Readiness for care coordination Gate 2	Demonstrated APC Capabilities Gate 3
	What a practice achieves on its own, before any TA or multi-payer financial support	***What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet***	***What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination***
		Prior milestones, plus …	**Prior milestones, plus …**
Pay-ment model	I. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	I. Minimum FFS with P4P[2] contracts with APC-participating payers representing 60% of panel	I. Minimum FFS + gainsharing[3] contracts with APC-participating payers representing 60% of panel

Measurement and performance milestones to follow

1 Uncomplicated, non-psychotic depression
2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework
3 Equivalent to Category 3 in the APM framework

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B Gate progression triggers outcomes-based payments aligned with CMS/multi-payer initiative and Medicaid levels

✓ Option for payment model after passing Gate

✗ Not a payment model option after passing Gate

Payment model options	Commitment Gate 1	Readiness for care coordination Gate 2	APC Gate 3
Category 1: Fee for service, no link to quality Payments are based on volume of services and not linked to quality or efficiency	✓	✗	✗
Category 2 / Medicaid level 0: Fee for service, link to quality At least a portion of payments vary based on the quality of efficiency of health care delivery (e.g. physician value-based modifier, hospital value-based purchasing)	✓	✓	✗
Category 3/Medicaid level 1 or 2: Alternative payment models built on FFS: Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk (e.g. ACOs, bundled payments, CPCI)	✓	✓	✓
Category 4 / Medicaid level 3: Population-based payment Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. eligible Pioneer ACOs in years 3-5)	✓	✓	✓

1 Partners include Anthem, Cigna, Montefiore, and United Healthcare, among others

Source: CMS Health Care Payment Learning and Action Network, NYS DOH

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C Additional detail: measurement and performance Milestones

Status TBD DRAFT

	Gate 1 Commitment	Gate 2 Readiness for care coordination	Gate 3 Demonstrated APC capabilities	Yearly performance against core measures within APC (determined in each payer/provider contract)
Performance on Quality			▪ >X percentile (Statewide on base year 2015) on 4/7 process quality measures[1] *OR if below X percentile:* ▪ 5 percentile improvement compared to own prior 2-year rolling baseline, up to 50th percentile, on 4/7 quality process quality measures	▪ Meet or exceed contracted quality benchmarks
Performance on Utilization			▪ >Y percentile on 2/3 utilization measures (Statewide on base year 2015 hospitalizations, readmissions, and ED use) *OR if below Y percentile:* ▪ Minimum improvement compared to own prior 2-year rolling baseline in 2/3 of the following measures: – Hospitalization: A% – Readmission: B% – ED utilization: C%	▪ Net positive ROI on care management fees through cost and utilization savings beginning in year three of transformation

1 Measures 2, 4, 5, 9, 12, 15, 16 from page 36- subject to change on an annual basis and upon roll-out of V2 scorecard

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Executive summary

- APC milestone achievement is **determined by TA entities in person** and **audited by an independent third-party** to ensure accuracy for payment purposes
- Both TA entities and practices are audited by a third-party Oversight Entity responsible for a **core set of activities** (e.g. audits, documentation portal, practice satisfaction surveys)
- Milestones **vary in level of verification** need and **intensity of verification will be tailored** accordingly
- Milestone technical specifications also **balance standardization and demonstration of performance with administrative burden**

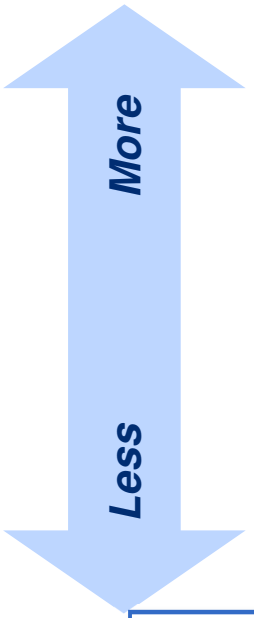
Recap: APC milestone achievement is determined by TA entities in person and audited by a third-party to ensure accuracy for payment

	Milestone determination	Auditing	Use
APC approach	▪ Entities delivering PT TA certify milestones	▪ Statewide third–party vendor	▪ CMMI, State, providers and payers
Rationale	▪ In-practice verification or milestones is resource intensive for thousands of practices throughout NYS ▪ It would be duplicative for each payer to do this	▪ An aggregator ensures consistent high-quality data is available ▪ A third party can audit vendors to minimize the effect of inherent conflicts of interest ▪ Scale statewide is unwieldy	▪ Accurate data based on in-person visits will ensure true practice change triggers continued financial support

CPCI and TCPI approaches are similar

Milestones vary in level of verification need and intensity of verification will be tailored accordingly

Verification needs



Description

- Essential service that forms the core of care coordination / care management payments
- Proxy for future performance on quality and utilization on core measures
- Activity where limited verification may allow for delivering an inadequate service

- Limited verification can still ensure that a high-quality service is delivered
- May require lower resource investments

All milestones will be subject to audit, allowing for appropriate oversight for milestones with less-intense verification needs

Milestone technical specifications also balance standardization and demonstration of performance with administrative burden

Criteria for technical specifications

Standardized	▪ Allow multiple TA entities to come to the same conclusion based on criteria
Balanced	▪ Balance administrative burden with need for demonstration of capabilities to trigger payments for one year ▪ Allow for appropriate flexibility to focus on improving performance on measures
Grounded in experience	▪ Synthesize the best lessons from other systems, including CPCI, PCMH-A, NCQA, and others

- Current draft intended for use in the first year of implementation
- Specifications to be revised on a yearly basis with recalibration of administrative burden vs. need to authenticate progress

Milestone: Access 2.i- Same-day appointments

DRAFT

Short description	Gate	Category
Same-day appointments	2	Access

Definition of "pass":

- Written policy and process for same-day appointments
- Assessment of practice's demand for same day appointments, with goal to satisfy at least 80% of demand

Input method: TA entity verifies practice information and submits to web app

Additional materials needed from State

- None

Elements required in submission of passing gate:

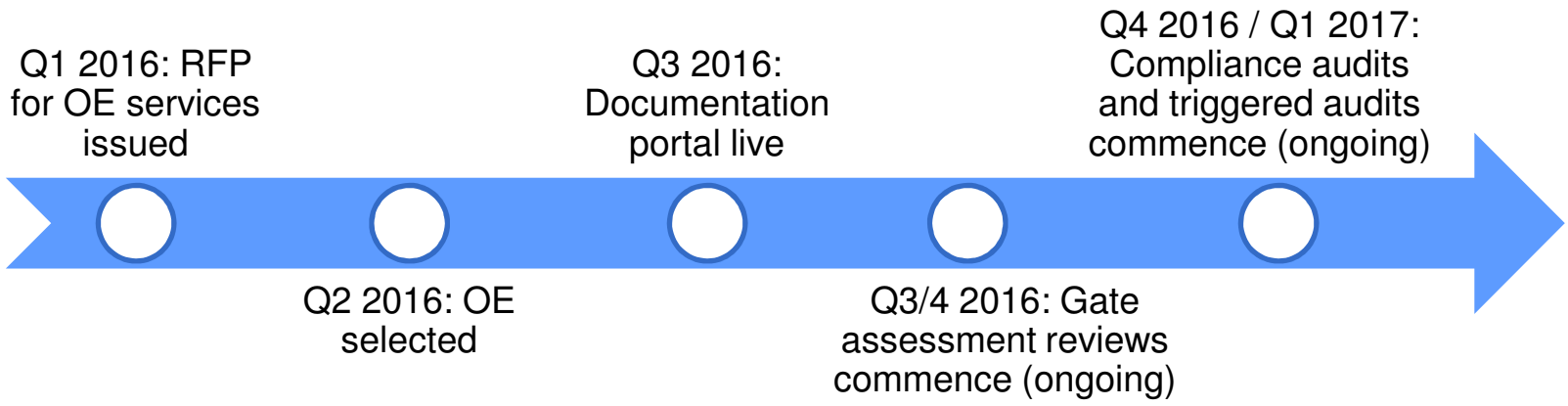
- Weekly schedule with slots for same-day appointments
- Report showing demand and % of patients seen in same day

Oversight Entity scope and timeline

Scope

- Audit both practices and TA entities participating in NYS's APC program
- Intended to create a trusted, independent, third-party review of practice achievements in the APC program and TA performance in support of practice achievements
- Through the Oversight Entity's verification and audit, practices may be deemed to have met certain gates, thereby making the practice eligible for value-based payments from both commercial and government payers

Timeline



Oversight: Key Activities (1/2)

Oversight Activities: High-Level Summary (DRAFT)

Activity	Description
Documentation portal	▪ Develop and implement a portal for practice and TA entity submission of gate and milestone documentation ▪ Role-based access for practices, TA entities, payers, NYS DOH, and oversight entity
Review Gate assessments	▪ Review documentation related to all TA entity gate assessments ▪ Establish standards for validity and reliability of assessments; findings used to educate TA entities and as input to audit plan
Audit plan for compliance and trigger audits	▪ Develop detailed audit plan for compliance audits and triggered audits for both practices and TA entities ▪ Educate and communicate activities to practices and TA entities about audit process

Oversight: Key Activities (2/2)

Oversight Activities: High-Level Summary (DRAFT)

Activity	Description
Compliance audits: practices and TA entities	▪ Practices and TA entities randomly selected ▪ Conduct compliance audits via phone and documentation review ▪ Perform reporting and follow-up activities after failed audits
Triggered audits: practices and TA entities	▪ Practices and TA entities selected based upon pre-defined triggers in audit plan ▪ Conduct triggered audits in person ▪ Perform reporting and follow-up activities after failed audits
Survey of practice satisfaction with TA	▪ Administer electronic survey approved by NYS DOH to assess practice satisfaction with its TA entity
Project management	▪ Regular project meetings with NYS DOH ▪ Monthly reports, six-month TA entity assessment, ongoing audit finding reports

Questions for you

For discussion

1. Given the scope for the Oversight Entity, what is your perspective on the level of oversight prescribed?

2. What is your perspective on the approach to technical milestone definition and level of standardization, administrative burden, and verification intensity?

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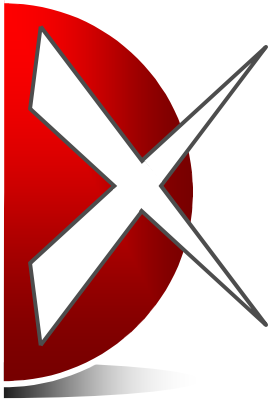
Overview of APC Scorecard discussion

What we'll cover today		Questions for you
1. Recap of the central role of the Scorecard in the APC program		
2. Overview of the multi-payer process required to create the Scorecard		
3. Discussion of the necessity of a Version 1.0 of the Scorecard as an interim solution		
4. Alignment on the best near-term option: a claims-based Version 1.0 (generated from State-aggregated numerator and denominator data from payers on 11 Core Measures)		*Do we agree that this Version 1.0 is the best available option?*
5. Presentation and feedback on current thinking about how Version 1.0 would work		*What is your feedback on our proposed operational approach?*

The Scorecard is a cornerstone of the APC program

What the Scorecard is:

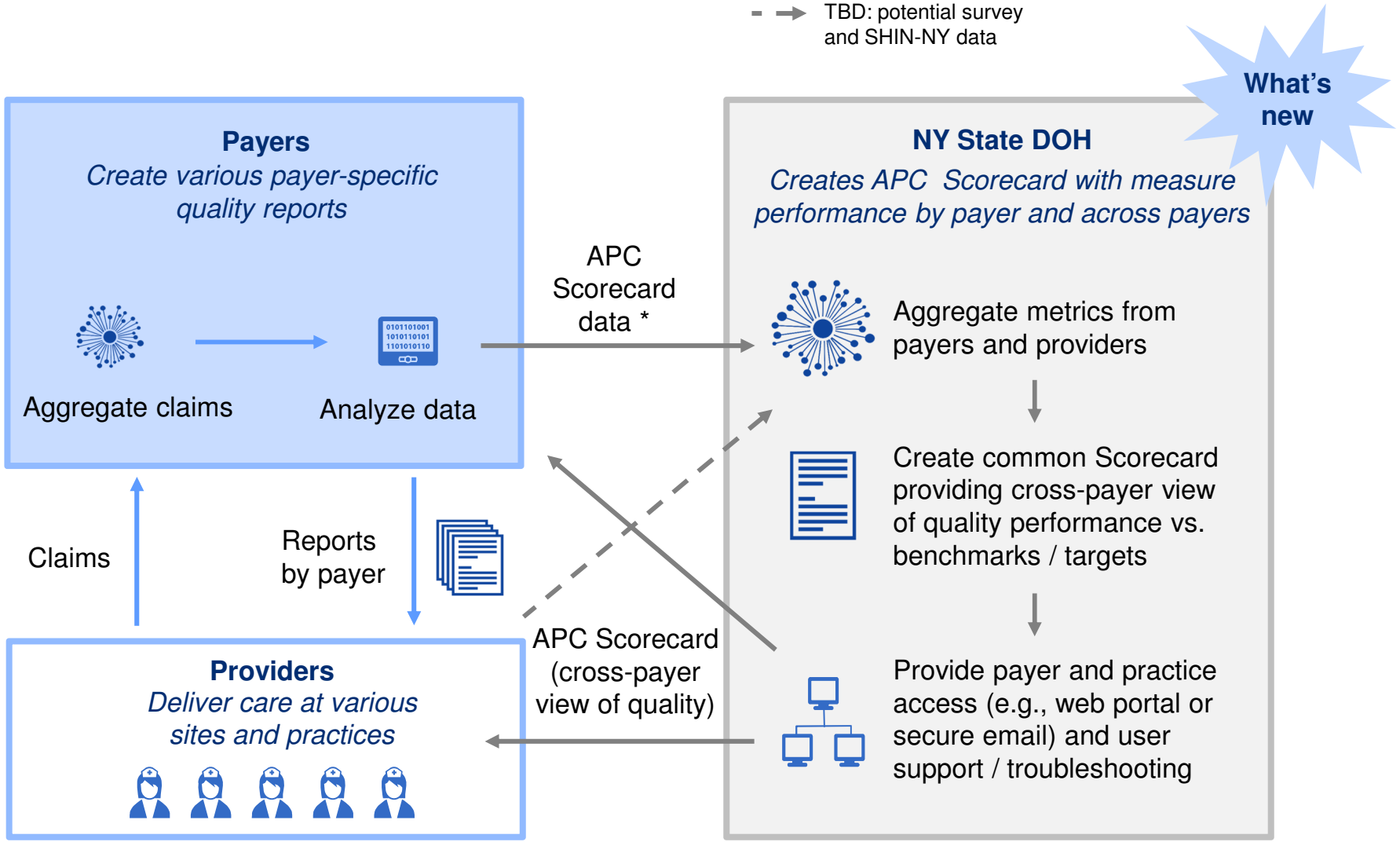
- A statewide report aggregating all primary care data relevant to APC Core Measures
- The first tool to enable practices to view their performance across a consistent set of measures for their entire patient panel (rather than on a per payer basis)
- The basis for practices to pass APC gates and access outcome-based payments



What the Scorecard isn't:

- A replacement for scorecards and measures required for ACOs, MA Stars, etc.
- A collection of brand new measures

Payers will play a critical role in the launch of the Scorecard



* NB: No PHI will be collected by the State

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Given the APD timeline, we need an interim Version 1.0 Scorecard

The **eventual APC Scorecard** leverages both administrative claims data from the APD and clinical data from EHRs.

The **timelines for APC launch and APD roll out do not align**. The APC program launches in 2016, while the APD launch is not anticipated until mid-2017.

We need **an interim non-APD solution** that:

- Uses easily accessible data
- Minimizes burden on providers and payers
- Is high quality and consistent across all types of patients and payers
- Leverages already existing processes
- Employs processes that can be used in future versions of the scorecard

A claims-based Version 1.0 is the best available option

☐ Recommended option

	Options	Considerations
A	**Payers submit numerators and denominators of measures to the State**	▪ Minimal burden on payers; uses easily accessible, already existing data ▪ High quality standardized data ▪ Builds towards eventual APD version
B	**Providers self-report (EMR and other data)**	▪ Burden on providers (not all have EMRs) ▪ Difficult to assure quality
C	**Payers submit raw claims to the State**	▪ Duplicative of upcoming APD ▪ Operationally challenging
D	**Individual payers send providers reports with a common measure set**	▪ Burden on payers and providers ▪ No synergies with eventual APD version
E	**Status quo: Individual payers send providers reports with no common measure set or cross-payer view**	▪ Burden on providers to receive and interpret varying reports ▪ No standardized measure set ▪ No synergies with eventual APD version

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Version 1.0 will focus on 11 of the total 20 proposed core measures

✓ Claims-only is possible Candidate V1.0 measures

Categories	Measures	Measure steward	Claims	EHR	Survey
Prevention	1 Colorectal Cancer Screening	HEDIS	✓	✓	
	2 Chlamydia Screening	HEDIS	✓	✓	
	3 Influenza Immunization - all ages	AMA (all ages) or HEDIS (18+)	✓	✓	✓
	4 Childhood Immunization (status)	HEDIS	✓	✓	
	5 Fluoride Varnish Application	CMS (steward), NQF, MU	✓		
Chronic disease	6 Tobacco Use Screening and Intervention	CMS (steward), NQF, MU	✓	✓	
	7 Controlling High Blood Pressure	HEDIS	✓	✓	
	8 Diabetes A1C Poor Control	HEDIS	✓	✓	
	9 Medication Management for People with Asthma	HEDIS	✓	✓	
	10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults	*Children*: HEDIS *Adults:* CMS	✓	✓	
BH/Substance abuse	11 Depression screening and management	CMS	✓	✓	
	12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS	✓		
Patient reported	13 Record Advance Directives for 65 and older	HEDIS	✓	✓	✓
	14 CAHPS Access to Care, Getting Care Quickly	HEDIS			✓
Appropriate use	15 Use of Imaging Studies for Low Back Pain	HEDIS	✓		
	16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	HEDIS	✓		
	17 Hospitalization	HEDIS	✓		
	18 Readmission	HEDIS	✓		
	19 Emergency Dept. Utilization	HEDIS	✓		
Cost	20 Total Cost Per Member Per Month		✓		

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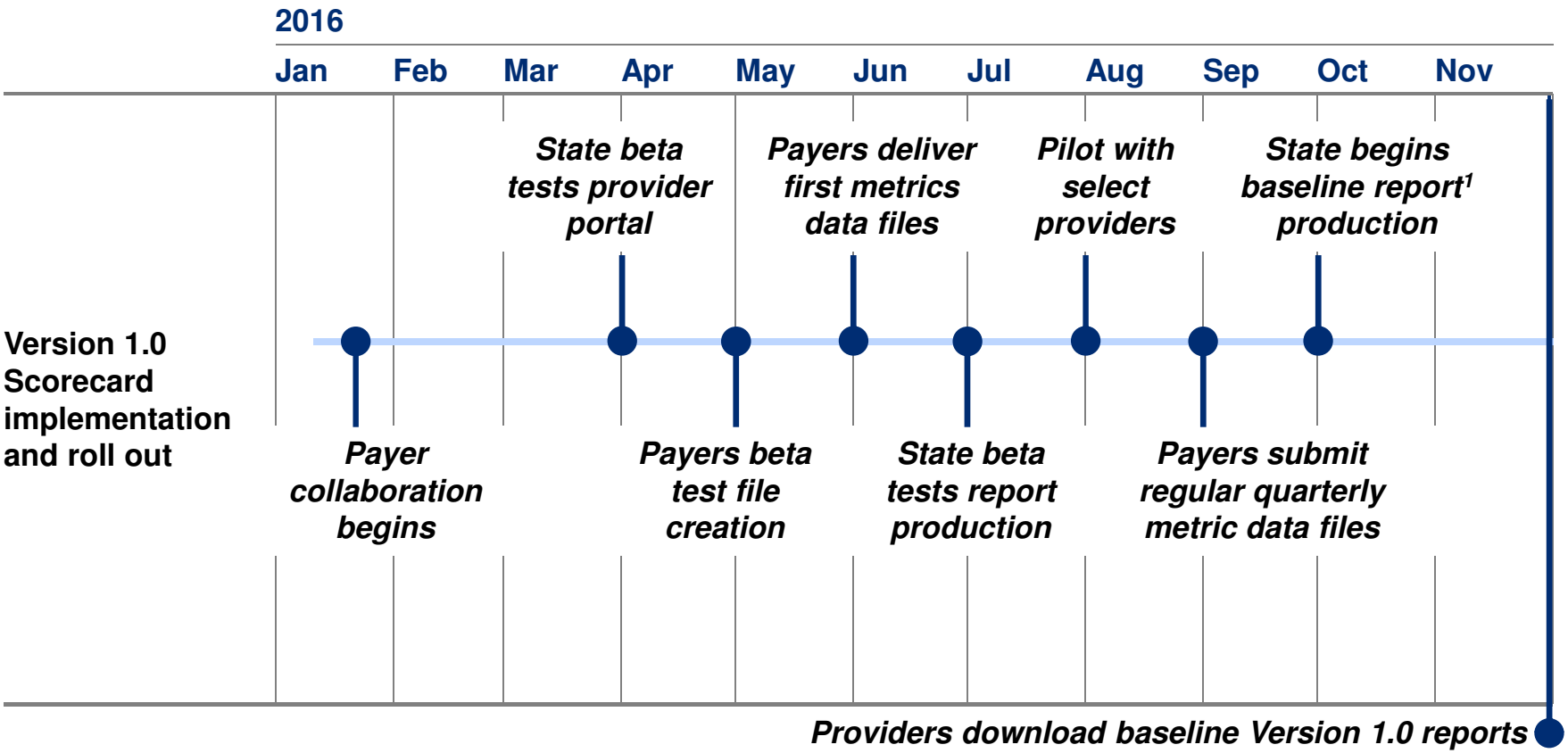
Operational approach: key features of Version 1.0

☆ Priorities for discussion

1	Measures	Eleven measures are proposed for Version 1.0
2	Reporting frequency	Reports produced quarterly, with one comprehensive annual report
3	Reporting window	12 month rolling window[1]; run out period of 3 months
☆ 4	Unit of reporting	Numerators and denominators should be reported at a provider, per site level *(NB: the State will not handle PHI as part of this process)*
☆ 5	Practice definition	Payers will send measure numerators and denominators at per provider per site level; practices will identify the physicians affiliated with their practices; state will aggregate into practice-level statistics
6	Data source	Version 1.0 will rely on administrative data only; later versions will incorporate clinical information as well
☆ 7	Patient to provider attribution	Attribution methodology will be left to payer discretion, but the methodology must be made transparent; payers will also provide attribution lists to practices to track which patients are included in the numerator and denominator for each measure
8	Population and risk adjustment	Measures should be calculated across all members for a given payer and risk adjusted according to existing measure guidelines.
9	Data submission format	Data will be submitted in a flat file data table through a data submission tool to IPRO
☆ 10	Provider eligibility	At minimum, payers will submit data for APC providers and for commercial, Medicaid, and Medicare Advantage lines of business; ideally payers will submit data for all practices
11	Timeline	Planned release date for Version 1.0 of the scorecard is December 2016

1 A period of 12 consecutive months determined on a rolling basis with a new 12-month period beginning on the first day of each calendar month

Version 1.0 launch is planned for December 2016



1 Baseline reports are based on recent 12-month performance

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Questions for you

For discussion

1. What are your thoughts / comments on the Version 1.0 approach?

2. What is your feedback on the proposed operational approach?

Next steps

We are following up with payers to:

- Further discuss measures and technical specifications
- Assess readiness for Version 1.0 scorecard implementation

These follow-up conversations will include:

- Medical director (with insight into your current primary care initiatives)
- Informatics leader (technical leader with oversight of the operationalization of measurement and reporting, HEDIS measures, etc.)

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01:30-02:00pm	APC working model for 2016 / closing	▪ Foster Gesten, Susan Stuard

Advanced Primary Care financial business case

- **The following pages describe the financial business case for APC payers and providers, including investments and returns over time**
- **Multiple other sources of value for payers to participate in APC, not described in detail here, are anticipated to include:**
  - Improved quality, outcomes, and patient experience
  - Positive influence on reputation
  - Ability to engage practices more effectively in aligned value-based payments, including practices with fewer plan members and smaller practices
  - Capture of quality incentives from Medicare and Medicaid (e.g., MA Stars)

Experience and research into dozens of examples of advanced primary care uncover many examples of both failure and success

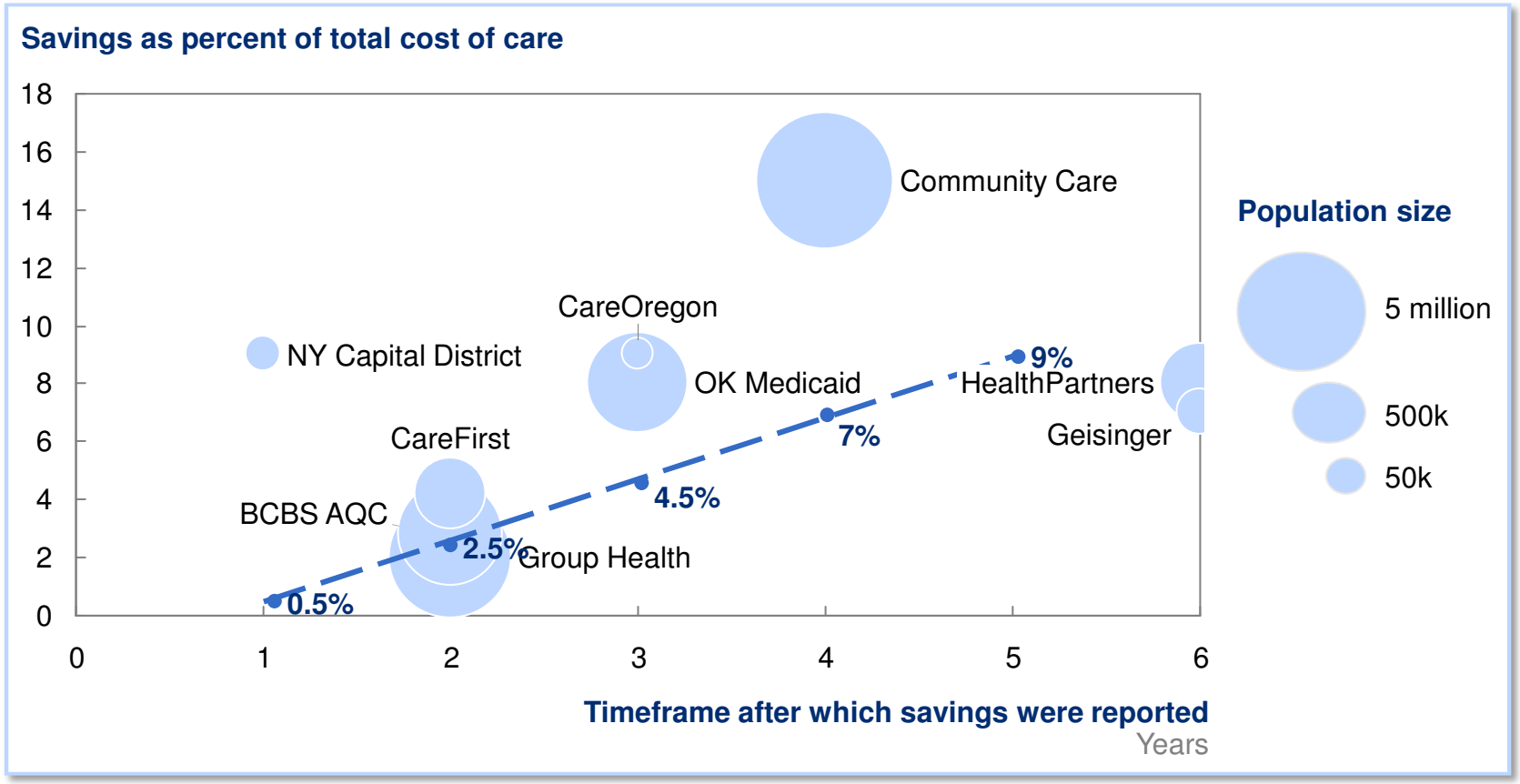
Most common modes of failure

- Physicians recruited with low expectations for need to change behavior/capabilities
- Sponsoring payer comprises small segment of provider's patient panel
- Disproportionate focus on screening and prevention, without reasonable prospects for near-term ROI
- Over-reliance on structural measures of quality, rather than process or outcomes
- "Box checking" mindset fostered by criteria for and approach to practice transformation

Key success factors

- Progressively challenging transformation milestones communicated up front
- Sponsoring payer(s) comprise high proportion of patient panel
- Relentless focus on managing high-risk patients to avoid acute events
- Transparency into data, analytics, and shortcomings
- Co-creation and stakeholder engagement to develop core group of clinical champions
- Physicians and office staff inspired to seize opportunity to "own their own change"

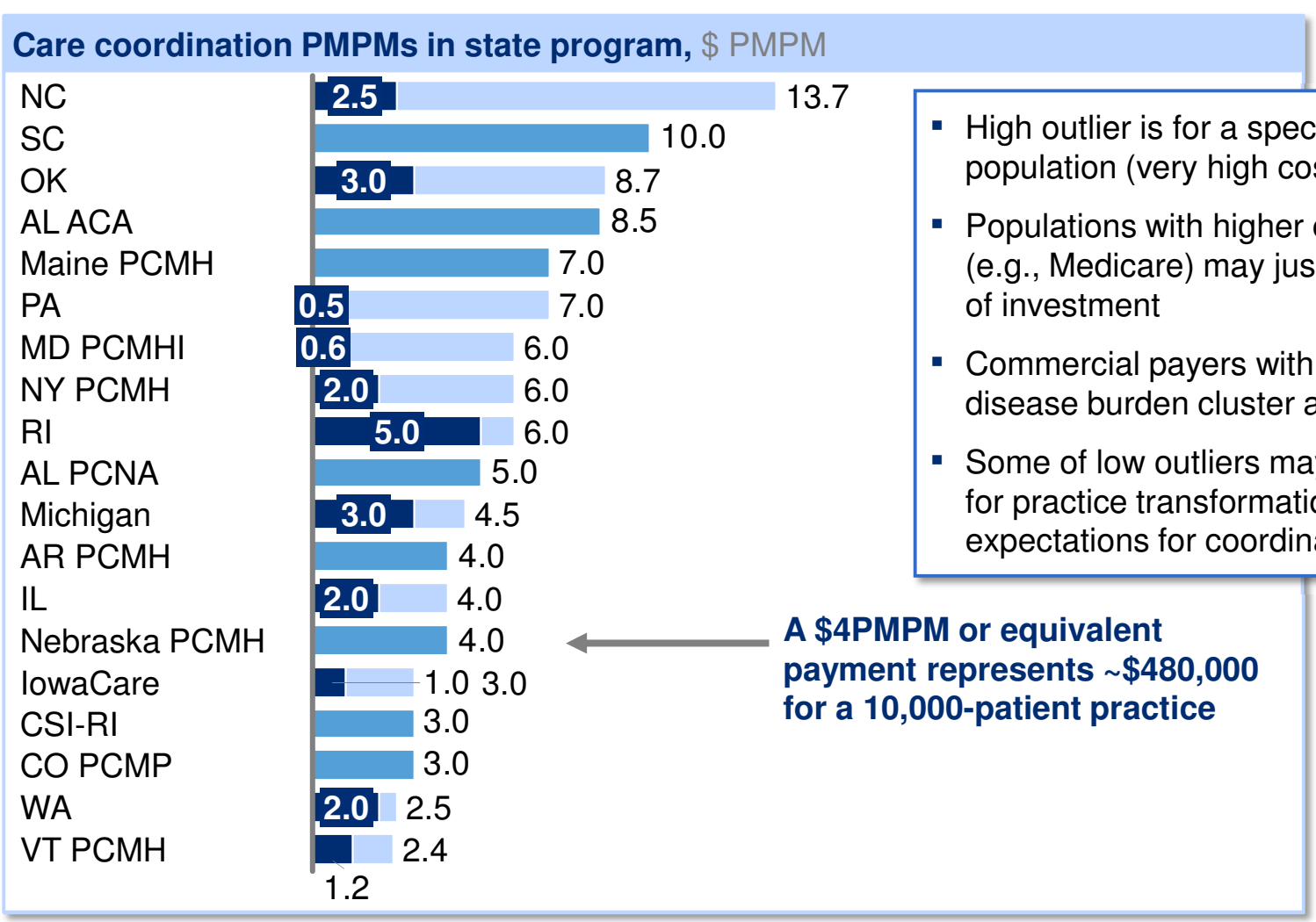
Our financial model draws on the evidence of other programs but assumes a more conservative ramp up



Source: Commonwealth Fund, Health Affairs, Milliman, Annals of Family Medicine, Patient-Centered Primary Care Collaborative, Agency for Healthcare Research and Quality

Care coordination assumption of $4-10 PMPM is based on payments in multi-payer programs averaging 0.5-2% of total cost of care

NOT COMPREHENSIVE



- High outlier is for a special needs population (very high cost)
- Populations with higher chronic population (e.g., Medicare) may justify a higher level of investment
- Commercial payers with lower chronic disease burden cluster at lower end
- Some of low outliers may reflect rewards for practice transformation without specific expectations for coordinating care

A $4PMPM or equivalent payment represents ~$480,000 for a 10,000-patient practice

Source: National Academy for State Health Policy, 2013

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Average total annual payment for care coordination tends to be roughly equivalent under three alternative methodologies

ILLUSTRATIVE

Care coordination fees for 10,000 patient panel[1]

	Healthy	Single chronic	Multiple chronic	Severe chronic	Population %	PMPM amount	Annual amount
Broad PMPM	✓	✓	✓	✓	100%	$3.90	~$480K
Targeted PMPM[2]			✓	✓	30%	$13.00	~$480K
Chronic care mgmt (CPT)[3]			✓	✓	30% x 30%[3]	$43.33	~$480K

It is possible to use any of three methods and create economic equivalence, depending on pricing level and patient eligibility. The above example is just a sample of possibilities

1 Commercial and Medicaid panels, excluding special needs populations
2 No expectation that coordination will occur for entire 30% eligible each month – see footnote #3 for assumption of monthly reach
3 Assumes only 30% of the eligible population have the code actually billed in a month (based on a care coordinator working 160 hours / month and 20 minutes of CC per patient in order to bill for CPT code)

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Care coordination cost estimate for technology and services

ILLUSTRATIVE

Illustrative practice with 10,000 patients

Operating assumptions

▪ Number of high-risk patients	1,000
/	
▪ High-risk patients per coordinator[1]	500
=	
# of care coordinators	**2**

Cost assumptions (per CC)

▪ Salary/benefits[2]	$95-120k
+	
▪ Access to specialized resources for high-complexity cases[3]	$25-40k
+	
▪ Management overhead[4]	$30-40k
+	
▪ Technology investment	$70-140k
=	
Total	$220-340k
Total CC investment (2 CC's)	**$440-680k**

- This is a high-level estimate for resources required for an average practice for hiring a care coordinator and related coordination resources
- Although actual approach to care coordination may vary across practices, these estimates are likely still representative
- Many factors affect the actual costs for a practice, including current investment by providers and payers in care coordination resources

1 Total panel size over the course of a year
2 One coordinator at $95-120K/year in salary and benefits
3 One specialty staff per 5-10 care coordinators at $150k/year in salary and benefits (may include PharmD, social workers, other specialty staff)
4 10-15 managers for every 100 care coordinators at $200k/year in salary and benefits

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Key assumptions underlying payer and provider business case

Pre-conditions

- **Participating payers:** comprise a majority of provider's revenue (at least 60% of panel)
- **Improvement mindset:** as a process of improvement focused on outcomes, where physicians and office staff are program creators and office champions
- **Improvement strategy:** centered on high-risk patients, data, and performance
- **Expectations:** to demonstrate progress prior to receiving alternative payments

Investments

- **$1.50-3 PMPM ($18-36 PMPY) or similar in financial support during transformation**:
  - Total cost of care (TCC) in NY: $440PMPM (Commercial) to $980PMPM (Medicare)
  - 6-12% of TCC in all settings paid to primary care under FFS ($30-60 PMPM)
  - 5% drop in PCP productivity during 2-year transformation
- **$4-10 PMPM ($48-120 PMPY) or similar payment for care coordination**
  - TCC: $440-980 (as above)
  - Care coordination payments 0.5-2% of TCC
- **Outcomes-based payments** representing 30-70% of savings, net of other investments

Impact on cost of care

Base case consistent with well-executed models

- Fully offset care coordination fees by year 2 (some earlier)
- Progressively improve to achieve 6-12% gross savings by year 5

Minimum case to remain in APC

- Demonstrate improvements in efficiency by year 2
- At least offset care coordination costs by year 3

Source: NYS SIM financial analysis, June 2014, National Academy for State Health Policy

Executive summary (providers)

Providers

	Category	Magnitude assumptions	Example for 10,000 APC-covered patients
Costs of new services	Time and productivity losses	**5% reduction in productivity** associated with changing workflows and engaging in, learning, and translating technical assistance (TA) sessions in the first year (TA funded by State grant)	($180-360K) (1 year)
	HIT investments	For those without an EHR, Installing and owning EHR can cost between **$15-70K per provider over 5 years** ($20-30K in the first year, $4-8K in subsequent years[1])	Assuming 6 providers: First year: ($160-200K) Subsequent: ($25-50K)
	Care coordination/ management	Costs of investments, overhead, and staffing for care coordination / management (assuming services provided for **10% of panel, 500 high-risk patients per coordinator**), whether shared or within the practice	($440-680K)
Multi-payer returns	Offsets for practice transformation time/ productivity loss	Payments for one year after meeting Gate 1, both for Gate 1 capabilities and as an investment in improvement, on the order of **: $1.5-3 PMPM or equivalent**	$180-360K (1 year)
	CC/CM payments	Payer payments for care coordination and management for their members, on the order of 1% of total cost of care **($4-10PMPM or equivalent**)[2]	$480-800K[3] (depending on case mix)
	Shared savings	Assuming savings can be up to **6-12% of total costs of care by year 5, with 30-70% of savings shared** with providers	$300-800K
		Net return[4]	$320-830K

1 Healthit.Gov 2 Range based on commercial total cost of care of $440PMPM and Medicare $980 PMPM
3 Range reflects different combinations of commercial, Medicare, and Medicaid 4 Averages HIT investments over 5 years

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Executive summary (payers)

Payers

1 *What will participation in APC cost for a payer?*

- Private payers will be expected to support Advanced Primary Care practices caring for patients in their Commercial and Medicare Advantage service lines
  - **Support to offset 1 year of productivity losses of practice transformation (PT)** ($1.5-3 PMPM or similar) for practices starting at Gate 1
  - **Investment in care coordination (CC) fees** ($4-10 PMPM or similar) after passing Gate 2 for one year, and continued after Gate 3 contingent upon meeting performance requirements
- For a representative payer with 10% market share, this could represent an **investment of ~$10M in 2017 (~$2M in PT support and ~$8M in CC fees)**

2 *What's the return for payers?*

- Success cases from multiple published multi-payer initiatives suggest a **pay-back period of 2-3 years and cumulative return of 3-4x by the end of 5 years** from start at Gate 1
  - In 2017, returns for a payer with 10% market share can be from $15-25M, driven largely by advanced practices who enter APC at Gates 2 and 3
  - By 2019, net returns for a payer with 10% market share can range from $90-135M per year
  - Primary care practices participating and succeeding in APC can see up to 50% increase in take-home pay by their fifth year of participation

Returns for payers and providers by year of practice participation in APC

ILLUSTRATIVE

		By year starting after Gate 1[1]				
		Year 1	Year 2	Year 3	Year 4	Year 5
Gross savings (% of TCC)[2]	**Target range**	0-1	2-3	4-5	6-8	6-12
	Minimum	0	0.5	1	2	3
Investments (% of TCC)	**PT support**	(0.5)	--	--	--	--
	CC fees	--	(1)	(1)	(1)	(1)
Net savings based on target range of impact (% of TCC)	**Total surplus**	(0.5)-0.5	1-2	3-4	5-7	5-11
	PCP share[3]	**0**	**0.5-1**	**1**	**1-2**	**0-2**
	Payer share[4]	**(0.5)-0.5**	**0.5-1**	**2-3**	**4-5**	**5-9**
PCP impact	As % increment to FFS[3]	**0**	**5-8**	**10**	**10-15**	**0-23**
	As % increment to take-home pay[4]	**0**	**15-20**	**25-30**	**25-40**	**0-55**

- **Pay-back period for payers 2-3 years, with 3-4x cumulative return over 5 years**
- **PCPs start to see increased income in excess of CC costs by year 2-3**

1 All numbers rounded for ease of communication
2 Target range = savings demonstrated in successful population health management models. Minimum = necessary to remain in APC program
2 Assumes PCP is paid 50% shared savings relative to two-year historical baseline (similar to 60/30/10-weighted three-year baseline used by MSSP), MSR 2% of gross
3 Assumes PCP base reimbursement is 10% Total Cost of Care in Year 0, growing at 5% per year in base case. Exclusive of CC fees (assuming fee is to cover costs only)
4 PCP take-home is assumed to be 30-40% of PCP reimbursement- 40% used here as a conservative assumption

Source: SHIP financial analysis, IC WG documents

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Expected return on investment by calendar year for APC-participating payers

ILLUSTRATIVE

		2016	2017	2018	2019	Total target
All payers (new and continued investments)	**Investments per year,** Millions	$7	$150	$280	$330	$770
	Expected returns per year, Millions	$-	$200-350	$400-600	$700-950	$1,300-1,950
Sample payer (10% market share, new investments only)	**Investments per year[1],** Millions	$<1	$10	$20	$25	$55
	Expected returns[2] per year, Millions	$-	$15-25	$30-40	$50-65	$90-135

- Returns in in early years are driven by advanced practices joining at Gate 2 or 3
- Subsequent years see returns on practices joining at Gate 1

1 New investments assume 30% of existing VBP for primary care is repurposed for APC (and only 70% is new)
2 For new investments, excluding 30% of VBP already existing

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Questions for you

For discussion

1. What are your clarifying questions on the above business case?

2. What is your perspective on the value proposition of the business case for all stakeholders in pursuit of the Triple Aim?

Contents

Timing	Topic	Lead
10:00-10:30am	Welcome / updates on timeline	▪ Foster Gesten, Susan Stuard, John Powell
10:30-11:15am	Updates on model: Performance milestones, Behavioral health	▪ Foster Gesten ▪ Lloyd Sederer
11:15-11:45am	Approach to Gate determination	▪ Susan Stuard, Marcus Friedrich
11:45-12:00pm	Working lunch	
12:00-12:45pm	Update on APC scorecard	▪ Pat Roohan
12:45-01:30pm	Discussion of payer and provider business cases	▪ David Nuzum
01:30-02:00pm	APC working model for 2016 / closing	▪ Foster Gesten, Susan Stuard

As we approach the launch of APC in 2016, we are shifting to implementation of the model we have designed together over the past year

Moving from design to implementation planning requires a shift in workgroup focus:

From	To
How do we design the best APC model?	How can we implement the model to drive the intended impact?
Informal conversations with and between APC stakeholders	Structured, formal interactions with APC participants (e.g. payer information request due in February)
Understanding allied programs across the State	Aligning programmatic and operational aspects of complementary programs under the APC framework to maximize value

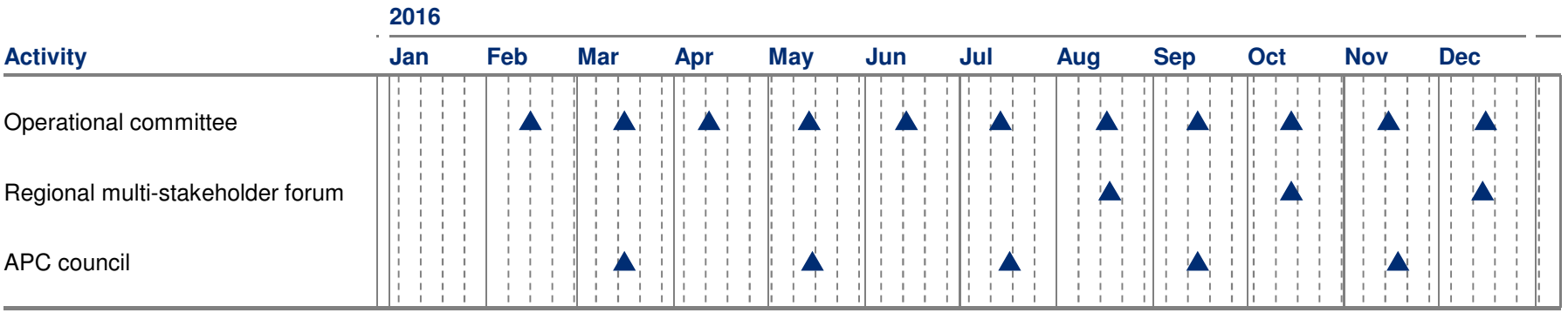
To facilitate this shift, meeting entities may also change focus

FOR DISCUSSION

Proposed entities	Description / participants	Role	Frequency
Operational committee	▪ Payers and providers that have committed to APC ▪ Statewide, with State convening	▪ Provide feedback on and proposals to improve implementation of APC ▪ Cross stakeholder dialogue to identify and resolve any critical issues	▪ Monthly to start (payer-only) ▪ Providers to join as implementation progresses ▪ Stakeholder-specific breakouts as needed
Regional multi-stakeholder forum	▪ Providers, TA entities, and payers (optional) meeting by region / multi-region group ▪ Facilitated by PHIPs or similar regional convener	▪ Discuss operational concerns by region ▪ Create regional reports to be reviewed by the State and discussed at APC council	▪ Every other month starting Q3 2016
APC council *(re-definition of ICWG)*	▪ Representatives of all stakeholders, with representation of regions when active ▪ Current ICWG members who choose to continue participating ▪ Statewide, with State convening	▪ Discuss ongoing progress by region and statewide ▪ Forum for coordination and adjustment with allied initiatives ▪ Advise State on changes to model	▪ Every other month (potential to progress to quarterly)

Success will be defined as the finalization and implementation of the APC model:
- **In accordance with the timelines previously set**
- **Positive trajectory toward meeting SHIP goal of 80% of New Yorkers covered by APC model**

Proposed 2016 timeline



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Questions for you

For discussion

1. What are your thoughts on the proposed meeting structure?

2. What do you think this structure neglects or over-supports?

Appendix

Additional key assumptions for payer and provider business cases

- **Ramp-up:** Very few payers and providers will execute contracts in 2016 (~2%)- though a large proportion will begin in 2017 (35%)- the remainder (toward a target of 80% of attributable members) will finish in 2018 and 2019
- **Business lines**: The following business case illustrates commercial (SI and FI) and Medicare Advantage business lines, where private payers have greatest discretion; the SIM program also anticipates participation of Medicare FFS and Medicaid (MCO and FFS) programs- though these are not illustrated in this case
- **Members reached through APC program:** Only members attributable to PCP (estimated to be 80% for total members[1]) can participate
- **Performance expectations:** 20% of practices will not meet performance requirements to remain in plan each year for the first four years, and will leave the APC program. Subsequently attrition is expected to be minimal.
- **APC gate upon entry into program:** Gate 1- 40%; Gate 2- 55%; and Gate 5%
  - Each practice will undergo a Gating Assessment co-sponsored by the SIM grant and participating practices in order to determine Gate upon entry
  - Allied programs such as NCQA PCMH, DSRIP, TCPI[2] will qualify for Gate 2
  - Practices participating in CPCI and MAPCP will qualify for Gate 3
- **Existing VBP for primary care**: Most payers have existing VBP programs for primary care (assumed in this case to affect ~30% of members). For individual payer examples, only 70% of APC investments are assumed to be new investments, leading to proportionately reduced new returns

1 20% of adults have not seen a provider in the last 12 months, CDC 2014
2 Most TCPI practices are expected to join the APC program in 2017, by which point many will be able to demonstrate Gate 2 milestones

Projected ramp-up and budget implications for APC payers[1]

ILLUSTRATIVE

	Line of business	Type of payment	2016	2017	2018	2019	Total target
Ramp-up assumptions by year, % of attributable members[1]	**All**	N/A	2%	35%	28%	15%	80%
Cumulative members remaining in program,all payers '000 members	**Commercial (SI + FI)**	Care coordination (CC)	75	1,700	3,600	4,300	
		Practice Transformation (PT)	50	1,100	900	500	
	Medicare Advantage	Care coordination	<10	190	400	480	
		Practice transformation	<10	120	100	60	
Investments per year, all payers, Millions	**Commercial (SI + FI)**	CC ($60 PMPY example)[2]	$5	$100	$215	$260	$580
		PT ($24 PMPY example)[3]	$1	$25	$25	$10	$60
	Medicare Advantage	CC ($108 PMPY example)	$<1	$20	$45	$50	$115
		PT ($24 PMPY example)	$<1	$3	$3	$1	$7
Total investments per year, all payers, Millions	**Commercial and MA**	All (CC and PT)	**$7**	**$150**	**$280**	**$330**	**$770**
Total new investments[3] per year, sample payer with 10% market share, Millions	**Commercial and MA**	All (CC and PT)	**$<1**	**$10**	**$20**	**$25**	**$55**

1 All numbers rounded for ease of communication and to avoid false precision
2 Care management fees may vary by payer in this range, and are presumed to be annual for all practices in APC
2 PT support may vary by payer in this range
3 New investments assume 30% of existing VBP for primary care is repurposed for APC

Source: Interstudy 2014, CMS, NCQA

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Advanced Primary Care model – frequently asked questions

	Purpose	Sections
What is APC?	▪ Introduce the scope of Advanced Primary Care, including its goals and key components ▪ Introduce the roles of key players	▪ What are the goals of the APC model? ▪ What are the components of APC? ▪ How was the APC model created? ▪ What can primary care practices expect from APC? ▪ How will APC practices be reimbursed under APC? ▪ What is the role of payers? ▪ What is the role of practice transformation technical assistance entities?
What are the benefits of APC?	▪ Motivate why key players should participate towards driving APC towards success	▪ Why is multi-payer alignment important to the APC program? ▪ What is the role of the State? ▪ Why would a payer participate in APC? ▪ Why would a primary care practice participate in APC?
Will APC work for me?	▪ Position APC in the complex landscape of providers and transforma-tion efforts statewide	▪ How can small practices participate in APC? ▪ How will TCPI, CPC, PCMH and other transformation initiatives be aligned with APC ▪ How will APC work with Medicare and Medicaid?
What is the timeline for APC?	▪ Outline key dates ahead for APC implementation	▪ What is the timeline for APC?

APC Structural Milestones largely match up with NCQA 2014, with a few elements specific to APC

- NCQA 2014 "Must-pass"
- NCQA 2014 other
- NCQA other, with slightly different details
- Not mentioned in NCQA 2014

	Commitment Gate 1	Readiness for care coordination Gate 2 Prior milestones, plus …	Demonstrated APC Capabilities Gate 3 Prior milestones, plus …
Participation	○ Early change plan based on self-assessment tool ○ Designated change agent / champion ○ Participation in TA Entity APC orientation ○ Commitment to achieve gate 2 milestones in 1 year	○ Participation in TA Entity activities and learning (if electing support)	
Patient-centered care	● Process for Advanced Directive discussions with all patients	○ Plan for patient engagement and integration into workflows within one year	▨ Engagement: survey, focus group, patient advisory council, or equivalent, plus QI plan based on results (yearly)
Population health			● Annual identification and reach-out to patients due for preventative or chronic care mgmt. ● Process to refer to self-management programs ○ Participate in bimonthly Prevention Agenda calls
Care Management/ Coord.		● Tracking system to identify highest risk patients for CM/ CC ● Ramp-up plan to deliver CM / CC to highest-risk patients within one year ● Behavioral health: evidence-based process for screening, treatment where appropriate, and referral	● Care plans developed in concert with patient preferences and goals ● CM delivered to highest-risk patients ● Referral tracking system ● Care compacts or collaborative agreements with medical specialists and institutions ● Post-discharge follow-up process ○ *Coordinated care management for behavioral health*
Access to care	● 24/7 access to a provider (synchronous and asynchronous communication with explicit response time goals)	● Same-day appointments ● Culturally and linguistically appropriate services	● At least 1 session weekly during non-traditional hours
HIT	○ Plan for achieving Gate 2 milestones within one year ● E-prescribing	● Tools for quality measurement encompassing all core measures ● Tools for community care coordination including care planning, secure messaging ● Attestation to connect to HIE in 1 year	○ 24/7 remote EHR access ○ Secure electronic provider-patient messaging ● Meet current Meaningful Use standards ● Connected to local HIE qualified entity and using data for patient care
Payment model	○ Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year	○ Minimum FFS with P4P[2] contracts with APC-participating payers representing 60% of panel	○ Minimum FFS + gainsharing[3] contracts with APC-participating payers representing 60% of panel

Must-pass elements make up only 27.5 points (out of 85 points needed for level 3)

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APC performance milestones are similar, with greater expectations for yearly performance

- NCQA 2014 "Must-pass"
- NCQA 2014 other
- NCQA "Must-pass", with slightly different measures
- Not mentioned in NCQA 2014

	Gate 1 – Commitment	Gate 2 – Readiness for care coordination	Gate 3 – Demonstrated APC capabilities	Yearly performance against core measures within APC (determined in each payer/provider contract)
Process	**Data collection plan:** Plan for collecting and reporting non-claims-based data relevant for core measures	**Report and use data** on all core measures[1], including data necessary to assess health disparities **QI plan:** Plan to achieve performance gate requirements by Gate 3	**QI plan:** on 3 prioritized core measures, including utilization and addressing health access and outcome disparities	
Performance on Quality			>X percentile (Statewide on base year 2015) on 4/7 process quality measures[2] *OR if below X percentile:* 5 percentile improvement compared to own prior 2-year rolling baseline, up to 50th percentile, on 4/7 quality process quality measures	Meet or exceed contracted quality benchmarks
Performance on Utilization			>Y percentile on 2/3 utilization measures (Statewide on base year 2015 hospitalizations, readmissions, and ED use) *OR if below Y percentile:* Minimum improvement compared to own prior 2-year rolling baseline in 2/3 of the following measures: – Hospitalization: A% – Readmission: B% – ED utilization: C%	**Net positive ROI on care management fees** through cost and utilization savings beginning in year three of transformation

1 Of measures being reported at that time (i.e., in 2016 the V1 scorecard will report on a subset of the 20 APC Core Measures)
2 Measures 2, 4, 5, 9, 12, 15, 16 from following page- subject to change on an annual basis and upon roll-out of V2 scorecard

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Several components of NCQA are not included in APC

- **2A**: Components for continuity (orienting patients to practice, ensuring access to preferred provider, documenting care plan for transition from pediatric to adult medicine)
- **3A**: Patient information and 3B: Clinical data– practice uses electronic system to record patient information as structured (searchable) data on basic factors
- **3E**: Implement Evidence-Based Decision support
- **5A:** Test tracking and follow-up

Source: NCQA PCMH 2014 Intro training slides